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ABSTRACT

This paper addresses issues related to the care of the aged by informal caregivers, government support of such care, and policy changes that might result in improved care of the elderly population. In its treatment of family responsibility for the elderly, it calls attention to several trends: (1) family members will be increasingly unavailable to provide care for their elderly relatives; (2) the elderly do not want to be too dependent upon family members; (3) the care of the elderly can result in serious economic, social, physical, and psychological costs to families; (4) these costs can result in abuse and mistreatment of the elderly; and (5) research findings do not support the assumed cost-savings from family care. It is questioned whether the United States and similar urban-industrialized societies can effectively adopt the practices of other types of societies in which the elderly are satisfactorily sustained by relatives. Examples are cited of Japan and Sweden where government provides financial incentives to families who provide for older relatives to live with them. A 1981 survey is referred to which found that more responsibility by government, as compared to more by the children of the elderly, or by the elderly themselves, was favored to a greater extent by the American public. Findings on international policies supporting family care of the elderly and its consequences are reviewed and the areas of assistance to families, mandating family support, and social changes affecting informal supports are addressed. (NB)

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POLICY ISSUES FROM AN
INTERNATIONAL PERSPECTIVE

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FAMILY CARE OF THE AGED
IN THE UNITED STATES:
POLICY ISSUES FROM AN
INTERNATIONAL PERSPECTIVE

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THE ORGANIZATION AND ITS MISSION

The International Exchange Center on Gerontology is an organization of centers and programs for gerontological research and teaching in both public and private universities throughout Florida. The University of South Florida is the headquarters or "host institution" for the IECG. The Center is new, having received its permanent funding in 1982, and operates under a Director and an Advisory Board of representatives from the participating universities.

The purpose of the IECG is to make available to policymakers in the State the best information that can be secured on policies, programs, and services for the elderly. This means collecting and analyzing experiences in such areas as transportation, health care, income security, housing, social services, nutrition, and other subjects that have a significant meaning in the daily lives of our elderly citizens. To carry out this mission, the IECG must communicate with political leaders, program administrators, academic institutions, and with experts in gerontology throughout the United States and the world.

Special attention will be given to program innovations, and to experiences that reveal both strengths and weaknesses in various approaches that have been tried in addressing the aspirations and needs of the elderly. Careful and frank exchange of information, and thorough analysis of policies and programs by policymakers and specialists in higher education offer an opportunity for examination from both theoretical and practical perspectives.

Florida has a unique opportunity for leadership in this field through the Center. Its concentration of elderly persons, and innovative programs like community care for the elderly, demonstrate the possibilities for both give-and-take of experiences. With assured continuing support, a small but highly qualified staff and faculty available in higher education throughout Florida, the IECG can develop a program that will greatly benefit all states. The pressures on state leadership to come up with wise decisions in human services is especially intense under the changing federal emphasis. The initiative is shifting more and more to the states, as federal funding is reduced. Useful information exchange will help state leadership to make increasingly difficult choices among competing priorities for limited funds.

Against the backdrop of a future which will feature exponential economic growth in the State, the influx of growing numbers of persons of working age, and the continuing increase in the number of persons over 60, Florida's policymakers need the best intellectual resources and insights that can be tapped. As a center for collecting, analyzing, and disseminating information of this quality and depth, the higher education community can be of inestimable service to the political and administrative leadership of Florida. The IECG can serve as a vital link between the universities and colleges, and state and local governments.

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Foreword

The primary purpose of Jordan Kosberg's paper is to present a perspective toward issues about care of the aged by informal caregivers, and support of such care through government, both here and in other countries; and to stimulate discussion about policy changes that might result in meeting the needs for care for an ever-increasing elderly -- especially an old-old -- population.

Dr. Kosberg's treatment of family responsibility for the elderly calls attention to a number of factors that too frequently are ignored in discussions of, and attempts to implement, policies designed to increase that responsibility. Such policies typically are pursued or promoted as a way of reducing costs to governments at all levels. Another dimension has to do with the question of whether the United States -- and similar urban-industrialized societies -- can effectively adapt the practices associated with other types of societies in which, presumably, the elderly are satisfactorily sustained by relatives.

A multi-country familiarity with the topic has among its advantages the realization that we as a country are not unique regarding our family support patterns, despite a widely held and promulgated vision that a pattern of neglect and even abandonment is common in America. The vast majority of the aged in our country do receive attention and support from their children -- if they have children. A critical issue, however, is how much more care provision is possible? Can we effect an increase in the proportion of families providing such care? And what about the quality of care that is possible among families?

Dr. Kosberg cites the examples of Japan and Sweden, where government

provides apparently effective financial incentives to families who provide for older relatives to live with them, even loans for fixing up or building homes; reimbursals for performance of home help services, etc. Other countries make direct payments to families who care for their elderly or who purchase services needed at home for an impaired elderly relative.

He also refers to the 1981 survey by Louis Harris for the National Council on Aging which found that taking more responsibility by government, as compared to more by the children of the elderly, or by the elderly themselves, is favored to a greater extent by the American public. As Dr. Kosberg notes, such findings are not congruent with the notion that Americans feel that there is "too much government." Perhaps this global notion does not apply concretely to the case of the aged in our society. Other findings from the same survey tend to buttress the point that, if proposed, there would be widespread backing for supporting home health services under Medicare or obtaining tax relief for families providing home care.

But just in terms of sheer demographics, or population statistics, the facts regarding the feasibility in the future of large-scale direct family support for the very old (i.e., those 80 and older) are not very encouraging. The number of younger adult relatives the very old of the near future will actually have will decline sharply. Today, for example, for every American 80 and older there are slightly less than four persons 55-64 years old -- the age group used here to represent the younger relatives who are ostensibly the persons expected to assume responsibility for the care of elderly family members. In 1970, the ratio was nearly five to one. By 1990, that ratio will drop sharply to only 2.8 to one, it will continue to decline for some

decades thereafter, and clearly will not return to the 1980 and 1970 ratios indicative of the "responsibility pool" for old-old relatives. Putting it more dramatically, the responsibility pool, from 1970 to the year 2000 -- only fifteen years from now -- be reduced by nearly 50 percent. Just between 1980 and 2000, the absolute number of old-old is expected to expand by 87 percent, in sharp contrast to only a 13 percent increase in the number in the "responsibility pool".

Thus it should be clear that even under the best of other conditions (discussed by Kosberg), direct family care for the elderly will require care for the caregivers on a scale never before contemplated, and will undoubtedly cause an intensification of the debate as to how the costs of care for the elderly will be allocated. By the end of the century, the debate may well be settled out of a confrontation with demographic reality. As Kosberg puts it, "Public policy which overly relies on the family as care providers for dependent elderly will have to acknowledge changes in the family constellation."

These changes are not unique to the United States, but the "policy response" may differ from one country to another. Other countries may be prepared more willingly to assist the families in a more satisfactory manner, according to criteria established by social gerontologists, and by families themselves. An irony may lie in the fact that, judging from the results of the national poll cited by Dr. Kosberg, the American public -- despite legislature and executive reluctance -- is in favor of some form of governmental financial assistance, through Medicare or "tax breaks." Awareness of the feasibility of such policies, when implemented elsewhere, may, however, induce the much needed changes.

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Family Care of the Aged in the United States:
Policy Issues From an International Perspective

by

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Recent trends in the United States regarding support for a growing older population include efforts to increase filial responsibility and reduce government expenditures. As will be discussed, efforts to emphasize family care of the elderly fail to acknowledge several trends. First, family members (especially adult daughters who typically are the family caregivers) will be increasingly unavailable to provide care for their elderly relatives. Second, the elderly do not want to be too dependent upon family members. Third, the care of elderly persons can result in serious economic, social, physical and psychological costs to families. Fourth, these "costs" can result in abuse and mistreatment to the elderly. Fifth, research findings do not support the assumed cost-savings which result from family care. Nonetheless, the family is still perceived to be a panacea in the care of elderly who are ill and dependent, the numbers of whom are expected to expand markedly.

America has looked enviously at other countries where the care of the elderly by family members is presumably supported by cultural norms, social values, and government policies. Demographic factors may also be among the forces associated with such support practices. These policies include financial assistance and relief to older persons and/or their families for care, as well as community-based services and programs. Two inter-related questions are: 1) can the United States adapt these programs and policies for family care of the elderly from foreign countries, and 2) are there changes in these foreign countries which will lead to modifications in policies and weakening of values supporting family care of the elderly?

It is the purpose of this paper to provide an overview of issues pertaining to the care of the aged by informal care providers, governmental support of such care in the United States and other nations, and policy revisions in the United States which could better meet current and future needs in care provision for the elderly.

INFORMAL CARE OF THE ELDERLY

Care of the elderly by family members is characteristic of the United States as well as in all nations of the world. In the United States, the relationship between the elderly and their families has been termed "intimacy at a distance," whereby the elderly live in fairly close proximity to family

members (Rosenmayr, 1977; Stehouwer, 1965), who visit rather frequently (Harris, et al., 1975; Riley and Foner, 1968), and provide a reciprocal exchange of financial and service assistance (Shanas, 1979). Generally, it is only with increased inability to maintain independent community living that an older person would become dependent on family and may, in fact, come to reside within the home of a family member. Often, though hardly desired by family or the elderly relative, movement of an elder person into the home of a family member is the preferred alternative to institutionalization of the older person. Although separate dwellings may be maintained by some elderly, family members often must provide assistance for many of the activities of daily living, including meals, medications, transportation, and housekeeping and personal grooming tasks, among others.

Gibson (1984), in a comprehensive article on international family support patterns for the elderly, points out that the United States is no different from such countries as Poland, Yugoslavia, Czechoslovakia, Japan, Canada, France, United Kingdom and Austria, among others, in that independence between elderly and families is maintained through living arrangements with rather frequent contact. It is only with increasing impairment, resulting in decreased ability to provide for one's self, that the family plays a major (or total role) in care provision.

CONSEQUENCES OF CARE PROVISION

Research findings in the United States have increasingly documented the consequences of family care to the elderly. Such writers as Zarit, et al. (1980), Horowitz and Shindelman (1980), Cantor (1983), Brody (1985) and Poulschock and Deimling (1984) have found negative social, psychological, economic, physical, and psychosomatic results to family members from the often unrelenting and demanding needs of dependent elderly relatives. These "costs" or "burdens" on the family are increased by the level and nature of impairments, the existence and involvement of family support for the major care provider of an elderly relative, and the degree to which the older person is a "provocateur" (Kosberg, 1983). The possibility that care providers are as impaired as the care recipient (such as an elderly child or spouse) or that the health of care providers have been adversely affected by the demands in providing care (a form of emotional or physical "burn-out") has resulted in professionals providing care for the care providers (i.e., family support groups) and a reclassification of "client" or "patient" to include the family system as well as older person.

An informal care system burdened, or otherwise stressed by the demands for care, may be unable to adequately provide the care needed by the older person. Adverse consequences to the physical health, if not overall quality of life, can

follow. The ultimate adversity to an older person by a burdened informal support system may be elder abuse (Kosberg, 1983). Whether out of ignorance, frustration, or anger, the dependent older person may be maltreated or abused. While Kosberg (1984) has indicated that most research on this problem has been carried out in the United States, the problem certainly exists elsewhere in the world.

Greengross (1981) has surveyed research on the consequences of family care to the elderly in the United Kingdom and found there were well over 300,000 single people caring for an elderly relative and these care providers were generally females, two-thirds of whom reported loneliness and exhaustion as the most prevalent problem. The result can be maltreatment. "The dangers of putting an unacceptable burden of care onto the family need to be recognized. The extent of non-accidental injury or 'granny bashing' in this country [Great Britain] is as yet unknown,..." (Greengross, 1981, p.23).

Gibson (1984) also has discussed the negative impact of the caregiving role in the world resulting, in the main, from isolation and confinement in care provision. She reports that two-thirds of the impaired elderly in Japan are being cared for by families experiencing serious difficulties which could result in a lack of adequate care. Further, primary caregivers in Australia and New Zealand were found to experience fatigue, anxiety, and other psychosomatic

consequences. Gibson (1984) further has reported on research findings from Germany and Australia where it was found that long-term care of elderly relatives results in family burden; in the United Kingdom one-half of single women caring for elderly relatives could not work outside of the home and this resulted in isolation and financial hardships; and in Scotland, a study of 112 family caregivers revealed that families experienced disruptions to their personal lives and were unable to leave alone their mentally-impaired elderly relatives.

Thus, the problem of adverse consequences to the family from caring for an elderly relative is hardly a phenomenon unique to the United States. Indeed, it seems somewhat prevalent in all developed countries around the world. As research findings substantiate adversities in developed nations, additional research is needed to determine whether burden to the family is experienced in developing nations and, if so, whether maltreatment of the elderly relative is a consequence (Kosberg, 1984).

GOVERNMENTAL POLICIES

A family may be unable to provide for the needs of an elderly relative because of financial expenses or because adults are employed (and unavailable to provide care). The dwelling may be already crowded. The family may fear that care to an elderly relative will curtail the freedom to come

and go and restrict privacy, and will negatively affect family relationships. The inability or reluctance to provide care has often been addressed through government efforts to provide assistance to families who care for their elderly relatives. This section will provide an overview of public policies in a variety of countries which are directed to two different areas of family assistance: 1) Financial assistance for care providers, and 2) community supporting services for families caring for elderly relatives.

Financial Assistance

Direct or indirect financial assistance for the care of elderly relatives has been discussed in the United States. Among various possibilities are those for tax incentives, direct subsidies, or direct cash payments to a care provider. While the United States Government has no national policy for direct payment, the State of Florida provides minimal subsidies to families or friends to cover basic support, medical expenses, and special care for dependent older persons.

Gibson (1984) states that tax deductions for family members who care for dependent elderly persons are available in the United States and Japan. "In the United States, persons who contribute more than half of the total support to an elderly relative whose income is less than \$1,000 a year (exclusive of tax-exempt income such as Social

Security) can count them as a dependent" (p.170). However, relatively few persons are eligible for such a deduction. Japan provides for income tax credit for families whose older relatives live with them and provides loans for caretakers to build or remodel their homes to accommodate an elderly relative (Maeda, 1983). In Sweden, family members performing home help service are reimbursed by the municipal government.

Far more usual than direct payment to families for care of elderly relatives are "constant attendance" cash allowances to be used to hire assistance or to reimburse families for the care of an impaired elderly relative. As Gibson (1984) points out, there is wide variation in the qualifying conditions for an allowance as well as in benefit levels. In France and Switzerland, a family means test is applied. In many Scandinavian countries, total disability is not required for eligibility. In Japan the constant companion allowance is only one-fourth of the disability pension, and in Belgium and East Germany the benefit is calculated on the degree of incapacity. In the United Kingdom, a constant attendance allowance is available to an eligible elderly person and an individual (not necessarily a relative) can also receive a constant attendance allowance. "While the United States does not provide a constant attendance allowance benefit under its Social Security program, the United States Veterans Administration does provide 'house-

bound' or 'aid and attendance' allowances to eligible veterans and their widows. These are payable respectively to veterans who are permanently housebound due to disability or to those who are in need of regular aid and attendance by another person" (Gibson, 1984, p.170).

These financial benefits for the care of the elderly vary in terms of adequacy for meeting the needs of the older person. Some policies seem more advantageous for the family and are, thus, a greater incentive to provide care. Caution must be given to economic incentives for family care of elderly relatives. "While policies for such financial assistance should be encouraged, care must be taken to insure the motivation for providing care for an elderly person is not an economic one and that financial payment to families do result in its use for the care of the elderly person" (Kosberg, 1984, p.21). Family screening should assess motivations and government policy should scrutinize the use of financial assistance to families.

Supporting Services to the Family

Ideally, family care should not be the only alternative for care of frail elderly; community-based resources should also be available. These alternatives can include various social settings which meet the needs of the elderly, such as public housing for the elderly, foster homes, group homes, etc. Also, community resources can assist the elderly to

live independently in their own dwellings so that movement to a more sheltered setting will not be necessary. Such community resources can include meals-on-wheels programs, home care and chore services, transportation assistance, telephone reassurance and friendly visitor programs, and home health care, among many possibilities. There is, of course, great variation between locales and between countries in the existence of these resources to maintain the elderly within the community, independent of family assistance.

Supporting services to those who care for elderly individuals is important, especially when the care is demanding and time-consuming. The "burdens" on caregivers are increased when there is not an extensive informal support system (i.e., extended family) to help share in the responsibilities of caring for an older person. In the United States, such needed community services to assist and relieve caregivers include adult day care, day hospitals, congregate meals programs, recreational opportunities, and respite care, among others. The existence of such community resources varies considerably, as does the eligibility and the auspices of such opportunities.

As Gibson (1984) states: "One of the most necessary services for families providing direct care to their ill older relatives is some form of respite care to enable the caregiver to have a night away from home or take a vacation"

(p.72). Respite care can include temporary placement within a long-term care facility or within a private home, or having someone who temporarily lives within the older person's home while the family is away. Gibson (1984) surveyed respite programs around the world and points out that New Zealand, France and Denmark have programs for temporary placements outside the home. Zurich, Switzerland has a "pensioners hotel" for short-term stays. Japan also provides a "short-term stay service" for when a caretaker of an elderly person becomes ill or has to leave home for an important purpose, such as funeral (Maeda, 1983).

In United Kingdom, short-term homes are being built under private auspices to relieve family members caring for elderly persons, placement of elderly persons in private homes with qualified "foster caregivers" is being expanded, "crossroads care attendant" programs provide part-time care in the home, and other volunteer programs provide relief to families caring for the elderly (Gibson, 1984). Home-help care for the elderly has been discussed as a "core service" in Sweden (Little, 1978) and is available in every community, relieving families of certain care responsibilities (i.e., shopping, cooking, housekeeping, etc.).

"Night-sitting services provide relief for one of the most common complaints associated with caring for a very ill older relative -- that is, having to get up several times during the night to respond to the latter's needs" (Gibson,

1984, p.174). She goes on to indicate that, although such services are not widespread, Stockholm provides night care assistance to elderly persons, as do several communities in the United Kingdom. Although few countries have such programs, the need for such assistance is increasingly being identified. For example, in Egypt "Night attendants should be provided when necessary so that the relatives of elderly persons who have restless nights can obtain some relief" (Fadel-Girgis, 1983, p. 592). Greengross (1981) has discussed an approach for the relief of families caring for the elderly in the United Kingdom. Called "Age Concern York," a voluntary organization will place elderly persons in need of short-term care into the home of an approved care provider or will provide a care provider into an older person's home for a limited period of time, thus relieving family members.

Respite for families caring for elderly relatives, whether through placement of temporary caregivers within the home or relocation of an older person into temporary lodging, varies from country to country. In the United States, respite care is acknowledged as important; yet, no systematic policy ensures either adequate or equitable assistance for all families. The development of a comprehensive system of respite care in the United States probably necessitates not only private and public financial resources, but also a system to certify the appropriateness of care providers and care settings.

POLICY IMPLICATIONS

The review of findings on international policies supporting family care of the elderly and its consequences has special meaning in the assessment of present United States policy and future policies. Three areas will be addressed: (1) assistance to families, (2) mandating family support, and (3) social changes affecting informal supports.

Assistance to Families

The United States is one of the few industrialized countries in the world without a comprehensive plan for the care of the elderly, whether through health or social policies (Oktay and Palley, 1980). The "welfare" form of government permits universal coverage of support without a means test (that is, without regard for financial need). Such universal support (be it for financial assistance or provision of services to the elderly or their families) is underwritten by the taxation of citizens. For example, seven West European countries with a population roughly equal to that in the United States devoted an average of more than 31 percent of gross national product (GNP) to social expenditures in 1981 (Marshall, 1984). In that same year, 21 percent of the GNP in the United States was devoted to social programs. In the United States, one of the few universal programs for the elderly -- Social Security -- is currently being debated in terms of whether a means test

should be employed in the determination of benefits. The adequacy of Social Security benefits, tied to the standard of living, and the "bankruptcy" of the program have long been discussed.

Cultural values and the history of the United States are incongruent with widespread support for "welfare state"-appearing policies embracing universal coverage for the care of the elderly. Such policies are contrary to both ideological support for "individualism" and a limited Federal governmental role in the affairs of state governments and the family. In addition, the complexity of the Federal structure, the distrust of government power, confidence in the private sector to meet social welfare needs, a tradition of low taxes, and strong sense of individual responsibility all result in the slow development of the welfare state in the United States (Nusberg, 1984).

The result is a system of care which is unacceptable to many in adequacy and availability of resources, state by state and locale by locale (Palley and Oktay, 1983). Or such resources for the aged may be available on only an experimental or demonstration basis (Nusberg, 1984). Generally, the less-affluent and the non-urban dwellers suffer.

Positive values regarding the active role of government in support of the problems of citizens can be witnessed in many countries. Benefits can include a vast array of

support for the aged and their families. "In 1982, when Sweden's first non-socialist government in 40 years proposed a cut back in sick leave payments, opinion polls showed that almost 60 percent of the public opposed the move and almost 40 percent were ready to protest by going out on strike" (Marshall, 1984). Half a million West Germans took to the streets, in 1982, to protest against planned reductions in social welfare benefits. Social welfare (including national health insurance) is supported by people in many countries, making a discussion of reductions of benefits or revisions of policies politically unpopular. The method by which to counter increasing costs of welfare programs in some countries is not by increased taxation or decreasing benefits, but by increasing efficiency of programs and controlling abuses (Marshall, 1984). In the United States there is talk not about increasing welfare coverage, but about cutting back social welfare programs, such as food stamps benefits, aid to one-parent families, veterans assistance, and Medicaid eligibility.

Clearly, the coverage of support to the aged and their families will not begin to approximate that found in other countries. Moreover, the cultural emphasis on volunteerism and voluntary support has not begun to approximate that existing in other countries, such as in the United Kingdom. Nusberg (1984) has indicated the importance of "heavy volunteer participation" in services to the elderly outside

the United States in such countries as Austria, Federal Republic of Germany, Norway, Sweden, and the United Kingdom (within which are "good neighbor schemes").

Paradoxically, it seems as if United States citizens do believe that it is the government which should be doing more to assist families to care for their elderly relatives. For example, a 1981 Louis Harris survey for the National Council on Aging of nearly 3,500 persons in the United States found that 54 percent of the total sample believed the government should assume more responsibility than it already has for the care of the aged (Harris, et al., 1981). This point of view was shared by 50 percent of the whites, 75 percent of the Blacks, and 75 percent of the Hispanics in the sample. The percentages apply to all persons 18 years of age and older, in each sex or ethnic grouping. As shown in Table 1, among those under age 55, 55 percent of the sample indicated that government should assume more responsibility than it now has for the elderly. But regardless of age, government was cited more frequently than children of the elderly, or the elderly themselves. Preference for increasing the role of the government in the care of the aged was inversely related to the economic level of the sample (Harris, et al., 1981).

TABLE 1

"Which of the following do you feel should assume more responsibility than they have now for the elderly?"

	<u>All Ages</u>	<u>18-54</u>	<u>55-64</u>	<u>65+</u>
Government	54%	55%	51%	50%
Children of the elderly	46%	50%	40%	34%
Elderly themselves	23%	21%	29%	27%

Findings of this sort do not completely confirm the notion that Americans believe that government is doing too much, at least as far as caring for the elderly is concerned.

Mandating Responsibilities

One method for minimizing government expenses in the care of the aged is by encouraging or mandating family support of elderly relatives. Such a notion has been discussed in the United States as a method of cutting federal costs and reaffirming filial responsibility.

Professional referrals of elderly clients or patients, as with probate court decisions regarding guardianship of an older person, generally involve family responsibility. Opportunities for subtle, if not overt, pressure by professionals on families, coupled with family guilt, are prod-

gious. As was discussed, placement of an older person into the care of family which is unmotivated or already overburdened can well result in maltreatment for the older person and exacerbate family problems.

Policies which seek to mandate family responsibility have moral and religious origins. In Great Britain, Elizabethan Poor Law emphasized the principle of primary family responsibility whose goal was "to protect the public from the burden of supporting persons who had family able to provide assistance" (Garrett, 1979-80, p. 781). British Poor Law pertaining to family responsibility was adopted by many states in America when public assistance (generally of a financial nature) was withheld until or unless it was determined that family was nonexistent or could not provide necessary care to a needy elderly relative.

Garrett (1979-80) has reviewed problems in the determination of dependency on an older relative, the adult child's ability to provide care and assistance, and other issues related to the implementation of mandating family responsibility for the independent elderly. He goes on to indicate that there is no rational basis for mandatory family responsibility policies, which are discriminatory against financially able children of impoverished elderly. Thus, such legislation is unconstitutional under the equal protection clause of the United States Constitution (Garrett, 1979-80). Research has also found that such

policies further impoverish less-affluent families (Callahan, 1980) and do not lead to significant public cost savings (Schorr, 1980). Moreover, such policies can be expensive to implement administratively.

But more than its constitutionality, mandating family responsibility can result in resentment by, and burden and stress on, the family, and embarrassment and guilt for the elderly relative. As a method of encouraging families to care for elderly relatives, and easing economic pressures on the families, financial incentives for caregiving by families have been discussed in the United States by way of public payments (Arling and McAuley, 1981), tax credits (Steinitz, 1981), or other forms of allowances or tax benefits. As an example of the relative wide-spread support for such incentives in the United States, the Louis Harris survey found 87 percent of the sample approved of the idea of Medicare covering more health services provided at home (Harris, et al., 1981). As shown in Table 2, 90 percent approved of the idea that families providing health care at home for the elderly should be given a "tax break" (National Council on Aging, 1981). Ethnicity, age, and income made virtually no difference in the virtual unanimity of approval for such a proposal.

TABLE 2

"Families that provide health care at home for the elderly should be given a tax break."

	<u>25-39</u>	<u>40-54</u>	<u>55-64</u>	<u>All Ages, 18 and over</u>
Strongly Approve	58%	63%	59%	58%
Approve	31%	29%	32%	32%
TOTAL	89%	92%	91%	90%

Elsewhere (Kosberg, 1984), it has been suggested that while such policies can be beneficial to the family, so too can they be a subtle form of coercion to motivate families for the wrong reasons to provide care for elderly relatives. So, too, have such proposals failed to assure the effectiveness of economic benefits to families or verify the appropriate use of benefits for the care of an elderly person.

Mandating family responsibility through public legislation is done infrequently in developed nations around the world and little is written about such legislation. As Gibson (1984) states: "Most...industrialized nations have abolished legal requirements obligating filial financial responsibility for elderly parents, or are in the process of

doing so" (p.78). As a matter of fact, assistance to families has been discussed as a disincentive to family care. As Greengross (1981) writes about British policy: "...many official pronouncements...suggest that any extension in the provision of formal services would undermine family responsibility further and encourage relatives to rely on the state, shirking their duty and abandoning their elderly parents to institutional care" (p.21).

In Worach-Kardas' article (1983) on family care of the elderly in Poland, it is pointed out that the issue of family as opposed to societal (that is, governmental) responsibility for dependent elderly is often a function of economic conditions. "The state's responsibility for meeting citizens' needs looks different in times of prosperity than in times of crisis, ..." (Worach-Kardas, 1983, p.594). While true, it is also a fact that when hard economic times befall a nation, so too are its citizens affected. Shifting responsibility from government to families in hard economic times would, no doubt, add burdens to those already burdened.

Japan requires family contributions in the institutional care for the elderly, though exceptions are made to this policy (Makizono, 1978). Yugoslavia requires families to care for ill and impoverished aged relatives (Greengross, 1981) but in practice, "few older persons are willing to report their children for non-support" (Gibson, 1984, p.

178). This is a major reason why such mandated responsibilities are so difficult to enforce in any country.

Although other countries are eliminating such policies, Gibson (1984) points out that United States policy is leaning toward "some filial responsibility for the costs relatives incur in nursing homes. Although several such measures have failed in Congress, Medicaid statutes have recently been reinterpreted by the Reagan Administration to allow states to force adult children and other relatives to pay for the cost of nursing home care" (p. 178).

The paradox exists that there can be policy disincentives for family care of the aged, either as a result of financially reducing benefits to the elderly being cared for by their families or by governmental support solely for institutionalization, thereby discouraging efforts by families. In the United States, chronically ill elderly receive little financial reimbursement for in-home services under Medicaid or Medicare; yet, Medicaid provides full reimbursement for long-term care of impoverished elderly (Gibson, 1980). In Israel, Weihl (1983) reports that elderly living with children must forfeit claims to welfare services (and may be denied nursing home placement). Needless to suggest, this paradox necessitates the existence of institutions for the aged to be available as an alternative to family care.

Social Changes

Turning too rapidly to the family as care providers for ill elderly presupposes the existence, availability and suitability of family members. Governmental policy which limits its focus only to family care furthermore fails to address those elderly without families (or whose families are unavailable to provide care) and fails to recognize changes in the family.

It is possible that community resources for the aged are available only to those who have informal support systems. For example, in the United States it is possible that use of day care programs, congregate meals resources, and recreational activities necessitate transportation service for all (or for the aged) in a community. Often home-based care, whether of a medical or social nature, is not provided because there are no informal supports for the older person. This situation, when benefits are available only to the elderly with families, is not limited to the United States. As Kendig and Rowland (1983) describe services for the aged in Australia: "The availability and amounts of support from community services remain very limited, however, and they provide genuine alternatives to institutionalization only when combined with substantial informal support" (p. 648). From a survey of mental health services around the world, Peace (1984) concludes: "Research has shown that it is those mentally ill elderly living with

family who are most likely to survive within the community, whilst those living with either an elderly spouse or alone are the most vulnerable to being institutionalized" (p.95).

As Brody (1981) has discussed, women (generally daughters) are the major care providers of the elderly in the United States. This is true, also, for the care of the aged in many nations (Gibson, 1984). Public policy which overly relies on the family as care providers for dependent elderly will have to acknowledge changes in the family constellation. Multiplicity of changes occurring in many countries can include lower birth rates which result in fewer children to support elderly relatives, decisions made by couples not to have children, more divorces and remarriages which can work to obscure family responsibility, multigenerational family networks where children of the elderly are themselves old, and the continuation of geographic mobility of both the young and old (including emigrations).

And, of course, public policies will have to reflect changes in the role of women whereby younger women seek careers outside the home and older women (after raising their children) seek education and careers. This phenomenon exists not only in the United States but also in many other countries as well, such as Japan (Maeda, 1983), Great Britain (Greengross, 1981), and Sweden (Little, 1978).

Finally, public policy must address the issue of priorities in the care of the elderly. Given limited financial resources for social welfare, should support of frail and dependent aged result from economic incentives and supportive services to their families? Or should these financial resources go to the care of elderly who are without families or whose families are unavailable or ill-suited (for economic or personal reasons) to be care providers? In the face of a lack of a definitive and comprehensive national policy for the aged and for the family, given the increasing trend of women entering the work force outside the home, the United States cannot avoid addressing the issue of policy priorities.

CONCLUSION

The experiences resulting from family care of the elderly are paralleled in many developed countries of the world. The national values regarding government and family responsibility for its citizens, and volunteerism, coupled with a form of government ranging in emphasis from a full-fledged welfare state orientation to one based on individualism and limited government responsibility, determines the system of care for elderly persons. While policies for and values concerning the elderly can be admired, care of the elderly is not without problems.

Policies which provide resources to families who care for elderly relatives vary from country to country. These resources can include financial assistance or benefits to families -- directly or indirectly. Community services, including chore and home care, transportation assistance, home health care, etc., can assist families in the care of the elderly. Programs can be available to relieve families of the often unrelenting demands resulting from providing care to frail and dependent elderly persons. Such relief can come through the existence of such programs as adult day care, congregate meals, night care, and -- especially -- respite care. Through these efforts, policies permit families to continue to care for their elderly relatives and forestall that day when institutionalization may be the only alternative.

Developed countries with such policies for assisting families caring for elderly relatives cannot meet all social, psychological, and physical "costs" of such care borne by families. Policies can only provide limited assistance to some families. Further, it appears that the same forms of social change which have taken place in the United States, affecting the family and its ability to be available and suitable for care provision, are taking place in many other nations. The geographic mobility of a population, the dynamics of birth and longevity trends, and "emanicipation" of women from the home and the dispor-

tionate growth rate of the "old-old," are but a few of the changing characteristics of nations around the world. How the changing demographics will affect values and attitudes regarding responsibilities for one's parents is still unknown.

Complacency regarding family care of the elderly needs challenging. Public sensitivity to, and awareness of, the problems of family burdens resulting from care to an elderly relative is imperative. Potential adversities for both family and elderly relative must be recognized and understood. While family care of an elderly relative may be consistent with cultural values, and supported or encouraged by legislation, it may not be the best solution to a problem. It should be emphasized, though, that the majority of families are already providing a very wide and intensive range of services to their elderly relatives -- directly and indirectly.

Finally, economic capacity of a nation is not the major consideration in the differences in care patterns for the elderly among nations. Attitudes and values regarding the role of the government in the care of the elderly and the responsibility of the family are the crucial factors. The United States could be doing much more for the elderly; could afford to do much more. However, until changes in attitudes and values occur, this nation will continue to approach the care of the frail and dependent elderly in a

nonsystematic way, unrealistically emphasizing the family as a panacea, and largely ignoring the consequences and social changes which have taken place, and continue to do so.

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